THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

RECREATION AND PARKS
DEPARTMENT

Columbus Recreation and Parks
Therapeutic Recreation
QUEST 2020-2021
Registration Form

Please complete this form as thoroughly as possible and return it to Mary Beth Moore, CTRS, at mbmoore@columbus.gov

I. Personal Information

First Name:_____ Last Name:_____
Address:_____City:_____ZipCode:_____
Male:____Female:____Date of Birth:_____Current Grade:_____Age:_____
School Attending:_____
Parent/Guardian:_____Best Phone:_____
Email:_____

II. Emergency Contact Information

Name:_____ Name:_____
Best Phone:_____ Best Phone:_____
Relationship:_____ Relationship:_____

III. Medical Information

Please circle all that apply to participant:

- ☐ Allergies (see below)
- ☐ Arthritis
- ☐ Atlanoaxial Subluxation
- ☐ Catheter
- ☐ Diabetes
- ☐ Diet Restriction
- ☐ Ear Tubes
- ☐ Glasses
- ☐ Hearing Aides
- ☐ Heart Condition
- ☐ Hepatitis Carrier
- ☐ High Blood Pressure
- ☐ Scoliosis
- ☐ Seizures
- ☐ Shunt
- ☐ Tracheotomy
- ☐ Other:_____

IV. Disabling Condition

To assist in ensuring proper staffing and safety, please identify the participants disabling condition. Circle all that apply to the participant and/or write in any disabling conditions or special instructions below.

- ☐ Arthritis
- ☐ Downs Syndrome
- ☐ Severe MR/DD
- ☐ Moderate MR/DD
- ☐ Vision Impaired
- ☐ Multiple Sclerosis
- ☐ Autism
- ☐ Attention Deficit Disorder
- ☐ Severe Behavior Disorder
- ☐ Mild MR/DD
- ☐ Hearing Impaired
- ☐ Cerebral Palsy
- ☐ Learning Disability
- ☐ Spinal Bifida
- ☐ Spinal Cord Injury
- ☐ Mental Illness
- ☐ Head Injury
- ☐ Muscular Dystrophy

Other:_____

Please provide specific information for any medical condition we should be aware of (Allergies, Activity Restrictions, etc.)_____

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Does participant walk independently? ☐ Yes ☐ No If no, what assistance is needed?_____ _____

Does participant dress independently? ☐ Yes ☐ No If no, what assistance is needed? _____

Does participant communicate through speech? ☐ Yes ☐ No If no, what type of communication is used?

Does participant bathroom/toilet independently? ☐ Yes ☐ No If no, what assistance is needed? _____

V. Medication Policy: Columbus Recreation and Parks Department staff shall not administer medication to participants in their programs. All medication taken by participant shall be self administered, and no participant on medication shall be registered in the program unless the person is capable of taking his/her own medications, or parent/guardian is available to administer the medication. Recreation staff may (1) Remind a participant to take medication and ensure directions on the container are followed, (2) Assist participant by taking the medication from the locked storage area and hand it to the participant, and (3) Assist participant with a physical disability in removing the medication, assist in consumption, upon request by or with the consent of the participant(s) parent/guardian.

Please identify type, dosage, and time all medication participant is currently taking.

Medication: Name	**Dosage**	**Frequency**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

VI. PUBLIC RELATIONS - Please initial one of the following:

____ I authorize the City of Columbus to use my son/daughter photograph/video for public relations purposes.

Or

____ I ***do not*** authorize the City of Columbus to use my son/daughter photograph/video for public relations purposes.

Therapeutic Recreation
CRPD Participant Information and Waiver

CRPD Therapeutic Recreation and Adaptive Sports Club of Columbus top priority is to keep our participants, volunteers, and staff healthy during this COVID-19 crisis and going forward. We are faithfully following the state of Ohio and CDC regulations to keep our entire CRPD/ASCC family safe.

I have received, read, and understand the protocols and policies for participating in _____(event).
Initials _____

PUBLIC RELATIONS - Please initial one of the following:
____ I authorize the ASCC/City of Columbus to use my photograph/video for public relations purposes.

Or

____ I ***do not*** authorize the City of Columbus to use my photograph/video for public relations purposes.

WAIVER
By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to, or infected by, COVID-19 by attending Adaptive Sports Club of Columbus/ City of Columbus Recreation and Parks programs, and that such exposure or infection may result in personal injury, illness, permanent disability and/or death. I understand that the risk of becoming exposed to, or infected by, COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Adaptive Sports Club of Columbus/City of Columbus employees, agents, representatives, volunteers and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any and all injury to my child(ren) or myself including, but not limited to, personal injury, disability, and/or death, illness, damage, loss, claim, liability, or expense of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at Adaptive Sports Club of Columbus/City of Columbus Recreation and Parks programs. On my behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge and hold harmless Adaptive Sports Club of Columbus/City of Columbus Recreation and Parks employees, agents and representatives, volunteers and program participants and their families of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.

PARTICIPANT/PARENT/GUARDIAN RELEASE
I authorize my child to participate in all activities offered during the program. If attempts to contact me at the above listed phone numbers are unsuccessful, I authorize and give my consent for any emergency medical, surgical or dental treatment for my child (listed above) anywhere/anytime should it be deemed advisable by a qualified medical doctor or dentist, and the transportation of my child to the nearest hospital reasonably accessible. I understand this is to avoid undue delay and to assure prompt attention/treatment in an emergency. I hereby give permission to the City/CRPD/ASCC to provide routine first aid care, administer prescribed medications in a life or death situation, and seek emergency medical treatment for myself or my child when deemed necessary. In case of accident or injury I will not hold the Adaptive Sports Club of Columbus/City of Columbus or its employees, agents and representatives, volunteers, program participants or their families responsible. I understand and assume all risks that may occur during my child's participation in these programs. I understand that should any injury occur to my child at this camp, I will be responsible for all medical treatment and other costs through my medical insurance policy and/or personal finances.

By signing below, I hereby acknowledge and agree to the policies and procedures set forth above.

Signature:	Contact #: (should health dept need to contact)	Date: